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Transgender in the Post-Yugoslav Space

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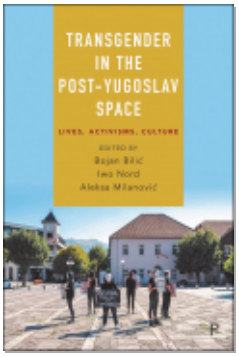

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Transgender and non-binary persons, mental health, and gender binarism in Serbia

Jelena Vidić and Bojan Bilić

Over the last three decades Serbia has been characterised by profound and occasionally violent social change.[1] In such a politically dynamic milieu little attention has been paid to trans issues and there are for the time being no systematic studies exploring the entanglements between transgender and gender non-binary (TGNB) persons, trans activism, and mental health. Our chapter starts filling this lacuna by combining both quantitative and qualitative data and offering an account of mental health-related challenges faced by trans people. After three introductory sections in which we provide an overview of research on TGNB mental health, describe the interface between transgender lives and the Serbian legal and health systems, and briefly present the history of transgender activist organising in the country, our analysis unfolds in three inter-related streams: first, we offer descriptive statistics arising from a 2019 survey about TGNB persons' needs and experiences: there we argue that in spite of legal and medical advancements, the right to gender self-determination is contentious and dependent upon the highly centralised health system which is still inadequately equipped to serve the population in question. In the second part, we draw upon the first author's year-long experience as a psychotherapist working with transgender clients in an activist organisation providing psychological support outside of the public healthcare system and gender medical team (thus not having a gatekeeping function). We examine some of the most recurrent issues that appear in individual clinical work with trans people emphasising how social status and geographical location modulate non-normative gender expression and the capacity to deal with the accompanying mental distress. In the third, final part, we turn to the transgender self-help group operating within the framework of the Belgrade-based activist organisation Geten (formerly known as Gayten-LGBT[2]). Above and beyond its empowerment function, we claim that this group constitutes an epistemic community that generates embodied knowledge about transgender lives that still lacks wider understanding

and social recognition. We point to potential policy implications of such insufficiently visible community-based strategies for improving transgender health and highlight the necessity of the official (mental) health institutions to incorporate them into their practice. While this group helps its members navigate the labyrinths of psychiatric/medical power, it does not always manage to wriggle out of normative gender binarism that pervades its wider socio-political space. In this regard, our trilateral approach enables us to start tracing the genealogy of gender binarism within the Serbian medical setting. We claim that despite significant improvements of the situation of TGNB people concerning psychiatric gatekeeping and legal gender recognition, TGNB community in Serbia is still marginalised with mental health being one of the most affected areas. With this in mind, we conclude by arguing in favour of a non-binary understanding of gender as a basis for gender-affirming (mental) healthcare.

TGNB people and mental health

Gender is a fundamental social category that organises personal and interpersonal experience throughout the life-course and helps us make sense of the social world by serving as a primary criterion for classifying people (Fassinger and Arseneau, 2007). TGNB persons have a gender identity that differs from the one assigned at birth. Such persons undermine traditional gender norms and may problematise deeply entrenched binary understandings of gender (gender benders, genderqueer, agender, bigender, third gender, and so on) according to which human beings are divided into men and women. TGNB people have recently gained global visibility accompanied by high levels of transphobic discrimination in a range of contexts including family, peer groups, educational institutions, workplace, partner relationships, and public space (Turner et al, 2009; Grant et al, 2011; Testa et al, 2012; Bockting et al, 2013; Robles et al, 2016). Various forms of anti-trans prejudice interfere with TGNB persons' access to basic human rights including medical and counselling services (Smiley et al, 2017).

Discriminatory attitudes that devalue TGNB persons may lead to different forms of stigma, such as harassment and violence as well as to self-stigma (as an internalised anti-trans prejudice). A systemic bias based on the idea that gender identities are assigned at birth and are not a matter of self-identification may negatively affect TGNB people's mental health. Indeed, the growing body of research related to the mental health of TGNB population has shown that they are at disproportional risk for negative mental health outcomes when compared with the general population (Grant et al, 2011; McNeil et al, 2012; Bockting et al, 2013; Budges et al, 2013; Smith et al, 2014; Smiley et al, 2017; White and

Fontenot, 2019). TGNB persons are more likely to become estranged from their families and may be more easily rejected by their peers and their wider social environment which, in turn, compromises their emotional wellbeing (McCann and Sharek, 2016; Aylagas-Crespillo, García-Barbero, and Rodríguez-Martín, 2018; White and Fontenot, 2019). High levels of stigma and discrimination, compounded with material hardship, may lead to anxiety, depression, suicidal ideation and attempted suicides, and various life-threatening behaviours (for example, substance use), particularly among transgender youth with insufficient parental support (Simons et al, 2013; McConnell, Birkett, and Mustanski, 2016; Robles et al, 2016; Veale et al, 2017; Taliaferro, McMorris, and Eisenberg, 2018; Valentine and Shipherd, 2018). Thus, a study conducted in Ireland (Transgender Equality Network Ireland, 2013), for example, showed that 78 per cent of transgender people had considered suicide. The situation is exacerbated by the fact that healthcare services are often not sensitive towards transgender issues and that psychotherapists lack skills for working more effectively with transgender clients (McCann and Sharek, 2016; Ho and Mussap, 2017; Valentine and Shipherd, 2018).

Moreover, TGNB people may be reluctant to seek mental health assistance due to fear of discrimination and rejection in medical settings that have a long history of trans pathologisation. All the way until 2019, the International Classification of Diseases (ICD) categorised various transgender and non-binary identities under the code F64 (gender identity disorders within the broader category of disorders of adult personality and behaviour). This was described as a disorder characterised by:

> a desire to live and be accepted as a member of the opposite[3] sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (WHO, 2016)

Such a psychopathologising view of TGNB persons assigns great importance to psychiatrists who are responsible for giving the diagnosis and monitoring their patients for at least a year before allowing them to proceed to endocrinological and surgical treatment, in order to prevent regrets, but also as a form of social control aiming to maintain the gender binary. This includes the so-called real-life experience or real-life test referring to a period during which transgender individuals had to live full time in their preferred gender role (understood in a normative and binary way) and by doing so demonstrate that they are sure about and can be socially functional in their self-identified gender (WPATH Standards of care, first

to fifth edition; for example, Breger et al, 1979; Levine et al, 1998). During such a period they often cannot change their legal documents regardless of numerous difficulties they encounter in social life due to a lack of legal gender recognition.

The 11th revision of the International Classification of Diseases, which came into effect on 1 January 2022, has de-psychopathologised trans identities by removing them from the chapter on mental and behavioural disorders. Following decades of intense activist mobilisations and scientific research indicating that a higher level of mental health difficulties in TGNB people should be understood as a consequence of adverse life experiences due to prevailing stigmatisation (Robles et al, 2016), this revision has redefined gender identity-related health by eliminating diagnostic grounds for social and institutional stigma of mental disorder and marking a paradigm shift from a disease-based model to an identity-based model (Reisner et al, 2016a). According to the new classification, gender incongruence has moved into the chapter dealing with conditions related to sexual health. This has been done in order to ensure that transgender people will continue to have access to gender-affirming healthcare that can be covered by health insurance. Such emancipatory measures may further encourage the use of a 'participatory population perspective'[4] (Reisner et al, 2016b) that would lead to interventions specifically tailored to the needs of TGNB persons and increase the representation of TGNB individuals among health and mental health providers.

TGNB people in Serbia: laws, health, and discrimination

Until January 2019, there was no formal procedure in Serbia that would enable legal recognition of gender identity and allow changes of name, gender, and personal data (including the unique identification number/ unique master citizen number that contains information about gender). The long-term practice, which did not have sufficient legal grounding, made document updates entirely dependent on surgical interventions that also included obligatory sterilisation. The Family Law that is currently in force enables name change for persons older than 15, but civil registrars usually refuse to do a name update in those cases in which a chosen name does not correspond to the gender registered in legal documents. It is for this reason that TGNB persons opt for gender neutral names (such as Vanja or Saša) as a temporary solution until they meet the requirements for full legal gender recognition. Until January 2019 it was possible to update a person's name and identification number in legal records only with a medical certificate stating that the person has gone through a 'complete gender-affirming surgery'. However, given that there were no legally binding protocols, the procedures and the conditions that had to be met were not standardised

and differed from one case to another and across the country. The extent of such administrative difficulties and disturbing treatments (for example, asking for additional certificates from forensic pathologists to prove that the person's genitalia were 'adequate') has been captured by a study that showed that TGNB people in Serbia perceived them as their major problem (Zulević, 2012).

A step forward was taken in March 2012 when the Constitutional Court decided that registrars were the only competent authorities for changing gender-related information in legal records. It was also stipulated that a statement issued by a hospital regarding gender-affirming surgery performed on the patient needs to be recognised by registrars as sufficient evidence for an update of records. However, this decision has not managed to standardise legal practice and people were still facing various obstacles during legal gender recognition (Vidić, 2020a). Thus, in 2018 the Law on the Birth Registry (Službeni glasnik, 2018) was revised and in January 2019 a new rulebook was adopted that regulates the matter of name and gender change.[5] The rulebook stipulates that records should be amended on the basis of a certificate issued by doctors working in relevant hospitals (which effectively means only by those who are members of the Belgrade-based team working with the TGNB population to which we turn below). For such a certificate to be produced, the person eithers needs to be on hormonal therapy for at least a year or to have gone through gender-affirming surgery. Both options also presuppose psychiatric–psychological evaluation and monitoring as a starting point of a medically assisted transition. Even though it is better than legally unregulated practice that required forced sterilisation, the current legal solution has serious disadvantages: it medicalises legal matters, pushes the person into the healthcare system via psychiatric encounters (which also used to add to the gender-related stigma the stigma of being a psychiatric patient) and presupposes recourse to hormonal treatment that changes the body.

Regardless of the fact that gender-affirming surgeries have been taking place in Serbia for more than three decades (Vujovic et al, 2009), the operation of the Belgrade Team for Gender Identity was officially regulated only in 2012. Before that, persons interested in undertaking gender-affirming surgery were dependent on a narrow circle of medical experts in the domain of 'gender dysphoria' (Zulević, 2012; Marković Žigić, Zulević, and Maksimović, 2015). This not only often meant that the surgeons arbitrarily determined surgery prices that were too high for the majority of TGNB persons (when that service still had not been covered by the national health insurance system) but that medical interventions were performed in inadequate circumstances, sometimes outside of the regular working hours, without the necessary permissions and the knowledge of other employees and without proper documentation or post-operative care (Zulević, 2012;

Đurić, 2012).[6] In her study about the problems that TGNB individuals in Serbia face in various spheres of life, Zulević (2012, p 41) reports the experience of one patient:

> My surgery was scheduled for Friday at 9pm … I was already lying on the operating table when the doctor came in to tell me that we had to postpone the operation and that I should come back in three days … I had an impression that no one was supposed to know that my surgery would take place.

Particularly during the highly taxing 1990s, characterised by soaring inflation, international isolation, and rampant impoverishment, doctors employed by the national health institutions routinely diverted their patients to the private sector in which they also worked. This was also done in those cases in which the required services could have been offered by the state system, so that TGNB clients were unduly put under much stronger financial pressure (Đurić, 2012).

Another set of problems had to do with the fact that gender-affirming surgeries are relatively rare, so they are treated as exclusive opportunities for training medical students and junior surgeons. As a result, operating rooms could become crowded interfering with the patient's privacy and comfort. As one interviewee told Zulević (2012, p 41):

> The atmosphere in the operating room was like that at a football match. No one ever asked me for permission and I had an impression I was left with no choice. There were so many students bending over me to watch that one of them leaned on my head and I had to tell him to move so that I could breathe normally. In such a commotion one of them also bumped into me … I felt as if I was in a circus … but I did not protest because I feared they might refuse to perform the surgery.

With time the situation has improved and surveys register higher levels of TGNB persons' satisfaction with healthcare provisions (Zulević, 2012). In 2012 the Ministry of Health established the National Expert Committee for Transgender Disorders, which was renamed the National Committee for Transgender Conditions in 2017 as a response to the request that Geten sent to the Ombudsperson. At one of their initial meetings, the Committee adopted its rules of procedure and decided upon its area of competence stipulating that the following conditions had to be met for a person to be allowed to surgically align their physical appearance with their gender identity: first, the person needs to be more than 18 years old; second, they need to provide at least two referral letters by two

independent psychiatrists following psychiatric monitoring not shorter than a year; and third, they need to be on a suppressive-substitutive hormonal therapy for at least a year. The Health Insurance Ordinance entrusts the Committee with the task of determining whether the conditions have been fulfilled. Upon receiving a favourable decision of the Committee, the patient is sent to a tertiary referral hospital with 65 per cent of the costs covered by the insurance and 35 per cent by the patient themselves. In contrast to surgical interventions, the costs of hormonal therapy, its availability, or quality are still not legally regulated regardless of the fact that transgender persons are expected to receive it for the rest of their lives. While previous legal solutions took into account only those individuals interested in completely transitioning from one discrete gender category (man or woman) into another, the Belgrade medical team has recently been moving towards more individualised treatments. Only up to a few years ago it was impossible to obtain a favourable referral letter from a psychiatrist for hormone treatment unless the person stated that they wanted complete genital surgery and referred to themselves in binary categories. Hormonal treatment is now also increasingly available to those who claim non-binary gender identities.

Making legal recognition of gender dependent on complete medically assisted transition did not take into account the social aspects of the lives of TGNB persons going through such a process. Many TGNB people who opt for partial or complete gender-affirming treatments take hormones that lead to bodily changes and may live for years with gender expression that is incompatible with the one stated in their personal documents. Such prolonged incompatibility in the context in which there is a widespread perception that there should be a close relation between body, identity, and documents makes TGNB persons vulnerable to various forms of violence and discrimination undermining their physical and mental wellbeing. In this regard, according to a survey done by Transgender Europe in cooperation with Gayten-LGBT (later named Geten) in 2014 and 2015 (Vidić, 2020a), one fourth of all reported incidents were categorised as cases of discrimination (66 per cent of which were in one way or the other associated with the legal recognition of gender), 37 per cent pertained to physical violence, 21 per cent to verbal threats, and 8 per cent to sexual harassment. Similarly to other countries, trans women in Serbia were exposed to violence more than trans men as they were victims in 79 per cent of all transphobic incidents. Perpetrators also belong to different groups and include: administrative workers (16 per cent), health workers (8 per cent), policemen (25 per cent), while they are unknown in 29 per cent of cases. As in other examined countries, the percentage of incident reporting is very low due to lack of trust in institutions and expected transphobic reactions by those who should offer support and protection.

Trans activism in Serbia

Autonomous feminist activism has been developing in a more intense manner in the Yugoslav space all the way since the late 1970s, while the first LGBTIQ+ initiatives appeared throughout the 1980s, mostly along the route Ljubljana–Zagreb–Belgrade (Bilić, 2012, 2020). Activist efforts became difficult and sporadic in the beginning of the 1990s as Yugoslavia witnessed a political and economic crisis and eventually disintegrated through a series of decade-long armed conflicts. The first Serbian initiative for gay and lesbian rights – Arkadija – was launched in Belgrade in 1991 (the organisation was officially registered only in 1994 following a revision of the Penal Code, which decriminalised homosexuality). Even though Arkadija did not explicitly address the issues of TGNB persons, along with other anti-war and peace-oriented endeavours, it did represent a refuge for sexual and gender difference, which was severely marginalised in times of strong militarist and patriarchal sentiment.

It was only after October 2000 and the removal of the authoritarian regime of Slobodan Milošević that a new impulse appeared in the domain of LGBTIQ+ legal and social emancipation. In this context, Gayten-LGBT was established in Belgrade in 2001 as the first all-inclusive activist organisation paying particular attention to the rights and culture of trans, intersex, and queer persons. The organisation struggles to acknowledge their sexual, gender, ethnic, 'racial', age, health, and class differences, and was founded by its current coordinator Milan Agatha Đurić (see Đurić, this volume), a pioneer of transgender mobilisation in the Yugoslav space and one of the earliest members of Arkadija.

Over the last years, Geten has been active in drafting a bill that would regulate the domain of gender identity and the rights of intersex people starting with the right to self-determination as the fundamental guiding principle.[7] Taking into account the latest developments in the sphere of TGNB human rights and health, this bill envisions a legal gender recognition based fully on self-determination and a straightforward procedure for updating name and gender on legal records, introducing the option 'other' for non-binary people. This draft also proposes regulation in the sphere of trans people's legal continuity as well as their rights and obligations before, during, and after hormonal-surgical treatments. It forbids all forms of discrimination on the basis of gender or sex and envisions psycho-social support to trans and intersex persons and their families. It also accounts for the possibility for trans and intersex persons to access medically assisted procreation technologies.

Along with their legislative work and other intersectionally sensitive activities, Geten offers a framework for the operation of a self-help TGNB group (see Đurić, this volume). This group was started in August 2006 as

the first self-help initiative for TGNB people in the Yugoslav region. It is estimated that until 2019 more than 120 persons, coming from a range of countries, have been in one way or the other associated with it. This is an open group that on average gathers twice per month and welcomes members with varying degrees of commitment. The operation of the group is based on the principles of support, self-esteem, safety, and self-realisation. Topics that are usually discussed in group meetings include but are not limited to the sphere of rights and administration, transphobic discrimination, partner relations, sexuality, and family life. We take a more detailed look at some aspects of the work of this group in the following sections of the chapter.

Methods

In this chapter we rely upon three major kinds of empirical data: a survey with TGNB individuals, observations from year-long clinical practice with TGNB clients unrelated to the evaluation preceding medical transition, and semi-structured interviews with members of the self-help group. We address each of these in further detail. First, in 2019, Geten conducted a survey, co-coordinated by the first author, about the needs of TGNB persons in Serbia (Vidić, 2020a). The aim of the study was to gain an insight into the current status of TGNB individuals in the domains of education, employment, healthcare, and legal gender recognition. The online survey was shared via Geten's social networks and trans-affirming mailing lists between 15 August and 30 October 2019. The questionnaire included a combination of open- and closed-ended questions: seven questions referred to general personal data (gender, age, residence, belonging to minority groups, ability, citizenship), three questions to financial situation, six questions to education (highest educational level, current education status, gender expression during education, potential discrimination and violence in the educational system, dropping out of school), eight questions to employment (current employment status, gender expression as well as potential discrimination and violence at work), four questions to the need for legal, psychological, and peer support, and two questions to the perception of safety at home and in public space. A separate section was dedicated to trans-specific healthcare tapping respondents' experience and level of satisfaction with health services, discrimination, and violence in healthcare environments and their perceived priorities in the domain of trans healthcare. At the end of the questionnaire, all of the respondents had an opportunity to add their experiences, perceptions, and comments that were not captured by the survey. The questionnaire was filled by 90 respondents from around Serbia, but 18 of them were eventually excluded from the sample for not fulfilling the criteria for the participation in the survey (not giving consent, identifying as cisgender, or responding in a derogatory and mocking way).

In our analysis we offer summaries (descriptive statistics) about the sample and the most relevant examined dimensions.

Second, when it comes to clinical work, we rely on the experience of the first author who is a psychologist and certified psychotherapist working in this capacity within Geten. TGNB clients are mainly young adults (up to 30 years old) in the process of education or with an incomplete faculty degree and without financial independence from their families. They constitute a heterogeneous group with regard to their gender identity (both trans men and women and non-binary people), needs, and/or plans for medical gender confirmation procedures and stages of the process itself. Sessions are usually held once per week and last 50 minutes, while occasional consultations last between 50 minutes and one hour. Therapeutic work is psychodynamically oriented and based on gender-affirmative approach. In this chapter we will focus on the work with ten TGNB clients during the period of three years.

Third, in order to get an insight into the ways in which TGNB people narrate and make sense of their experiences, we draw upon ten semi-structured interviews with members of the Geten self-help group for TGNB people. The interviews were conducted by the second author in December 2019 with group members all of whom at the time resided in Belgrade (even though they may not be from there originally). The participants were recruited through the snowball sampling. The interviews lasted between 45 minutes and two hours and were recorded with an mp3 voice recorder. Every interview started with an opportunity for the interviewee to narrate a biographical episode associated with their self-help group participation. This was then explored in further detail on the basis of an interview guide. All of the interviewees received verbal information concerning the design and procedure of the study and gave their informed consent. The interviews were subsequently transcribed and analysed by using inductive thematic analysis with a view of identifying predominant themes in the dataset.

Finally, we complement our empirical corpus with other sources, including unpublished surveys as well as published research and newspaper interviews with trans activists.

Results

Survey

The examined sample (*N*=72) consisted of 31 per cent trans women, 35.2 per cent trans men, 29.6 per cent non-binary persons, and 4.2 per cent who perceive their gender in a different way. A vast majority of respondents is younger than 35 (82 per cent) and living in a town with more than 100,000 people (60.6 per cent); almost one fifth of respondents (18.3 per cent) belong to an ethnic, 'racial', or religious minority (including atheists, Romani people …), and 4.2 per cent stated to have some sort of a disability.[8] The majority

of respondents face different financial difficulties: more than one third of those older than 18 do not have any regular monthly income with only ten of them having a salary higher than the national average; one half of the sample is unemployed, 31 per cent has a (temporary) job, and 11.3 per cent own their own business. Two thirds report that their households experience difficulties when trying to make ends meet. In terms of education, the majority of respondents finished high school (50.7 per cent) or university (31 per cent) while one half were in the educational system at the time of the survey.

Respondents encountered different forms of discrimination and violence in various domains of everyday life. Almost one half (45.1 per cent) report that they never felt safe to express their gender identity at school, while only one fourth were never discriminated or exposed to violence by peers, teachers, or other school staff. Among the most frequent forms of violence were requests for normative gender expression (for example, 'the principal kept forcing me to have a haircut and verbally attacked me on numerous occasions regarding the way I dressed or looked'), ridiculing, physical or sexual abuse, and death threats mostly coming from fellow students. With this in mind it is not surprising that 33.8 per cent considered leaving school while 12.7 per cent actually did so. Fear of violence is the major reason for dropping out of school, whereas the decision to persevere is backed by internal motivation ('nothing in the world will put me off doing what I like') or existential concerns ('what could I do without a degree?').

Gender stigma has a negative impact on their professional lives as well. Perceived/anticipated stigma is evident at the work place: 62 per cent of respondents think that they do not have equal chances of finding a job in comparison with the members of the majority population with the same professional qualifications. Less than a half of the respondents are open about their gender at work so that 'everybody knows it' (20.4 per cent) or that 'most people know it' (22.7), while 36.3 per cent state that 'nobody knows about it' or 'only a few persons of trust'. Among those with work experience (currently employed or unemployed), 38.4 per cent had been exposed to gender-related violence or discrimination in the workplace and 21.7 per cent decided to quit their jobs because of it. One respondent stated that she left her job because she did not want to be treated as a man and another one was told he should come back 'once he has become a man'.

Four out of ten respondents (39.4 per cent) claim to have had difficulties in everyday life due to documents that do not align with their current gender identity and one fourth (25.4 per cent) suffered discrimination or violence because of this. Such discriminatory acts mostly pertain to minor resistances and misunderstandings (like police or administrative personnel not believing that survey respondents were actual owners of their legal documents), but a more serious issue is that inadequate documents prime

TGNB individuals to expect negative reactions and therefore avoid social situations in which legal documents would need to be shown. In this regard many respondents talked about their reluctance to visit a medical doctor because they assumed that there would not be sufficient knowledge or that they would encounter transphobia.

The majority of respondents felt a need for legal counselling (57.7 per cent) or psychotherapeutic assistance (63.4 per cent) in the year that preceded the survey. Nine out of ten respondents (90.1 per cent) stated that it was important for them to learn about the experience of other TGNB people or to confide in another TGNB person (85.9 per cent). Less than one half of the sample (45.1 per cent) have already used some form of trans specific (psychiatric, endocrinological, or surgical) healthcare (31 per cent have not so far, but plan to do so, 23.9 per cent have not and do not intend to) and one half of those (48 per cent) were either very dissatisfied (22.6 per cent) or dissatisfied (25.4 per cent). When it comes to psychiatric/psychological support as a part of trans-specific healthcare, 36.6 per cent of respondents were dissatisfied with them whereas 31 per cent were either satisfied or very satisfied and 32.4 per cent stated that the question did not apply to them. Such a high level of dissatisfaction with the psychological support is particularly worrisome in the light of a European survey in which Geten was the national coordinator for Serbia, which showed that TGNB people from Serbia had the highest percentage of suicidal ideation among the five examined countries (including Georgia, Poland, Serbia, Spain, and Sweden; Smiley et al, 2017): 85.9 per cent of respondents (55 persons filled the questionnaire and 38 ended up in the analysed sample) reported that they thought seriously about ending their life, 73.7 per cent multiple times, and 13.2 per cent once (Smiley et al, 2017). In the year that preceded the 2016 survey, 39.4 per cent of respondents stated that they thought seriously about ending their life. The same survey also demonstrated that 57.6 per cent of trans people with suicidal thoughts did not seek any help. Among those who did, 21.2 per cent did so among their peers, friends, or family, and only 12.1 per cent looked for support from a mental health professional.

Both surveys (2017 and 2019) demonstrate that TGNB people in Serbia share the predicaments of the general population in terms of poverty and unstable and badly paid employment. However, these social status parameters are aggravated by high levels of transphobic marginalisation and discrimination in practically all spheres of life, including both private and public spaces. Living in a centralised state in which all relevant institutions are located in the capital, many TGNB persons are deprived of their right to professional healthcare. The sphere of mental health is particularly affected as the wide majority of TGNB people are not sufficiently familiar with such services or do not have an easy access to them. This is not only due

to a shortage of qualified mental health professionals trained in gender-affirmative approach and a virtual absence of TGNB mental health workers apart from those included in the medical gender identity team but also to more widely held prejudicial attitudes towards those seeking mental health assistance. In the following section, we review some of the most frequent issues that appear in individual clinical work with TGNB clients.

Clinical work with TGNB clients

Geten has a broad and well-developed system of psychosocial support for LGBTIQ+ people, provided both by peers and mental health professionals. An LGBTIQ+ helpline and trans support group were founded in 2006 and have been available to LGBTIQ+ people for the past 16 years, and in the past decade team members have been providing psychosocial support via email and Facebook. In 2014 Geten introduced individual consultations, counselling, and psychotherapy with certified psychotherapists, and in the past couple of years this form of support was also provided as a separate activity on TIQ chat. Besides that, team members support the community by organising various benefit parties (mainly to provide financial support to TGNB individuals for medical interventions), support in the form of communication and advocacy with various institutions, advice on the matter of legal gender recognition, and so on.

In this section we will focus more on the support provided by mental health professionals. In the past six years more LGBTIQ+ people started contacting the organisation asking for counselling and in 2014 the first author, supported by the rest of the team, started providing psychological support in a more systematic manner as a part of her engagement within the organisation. Due to the increase in demand for this kind of support, another psychotherapist joined the team in 2019. In 2019, 310 individual sessions were provided by the two psychotherapists. Support is mainly offered in the form of psychotherapy, ranging from several months to several years. Due to limited resources, the continuous support soon had to be restricted to only students and unemployed LGBTIQ+ people, and LGBTIQ+ people in a better financial situation can schedule one consultation or ask for referral to some of the LGBTIQ+ affirmative psychotherapists working in private practice with reduced prices.

Concerns raised in therapy are to a certain extent similar to those raised by their cisgender peers; however, different manifestations of stigma, and particularly self-stigma, are colouring interactions with the environment and client's self-image. Given that the majority of clients seeking psychotherapeutic assistance are adolescents or young adults, it is not surprising that the most prevalent topics they raise are those related to the intersection of their families of origin with their gender identity. People who

have not shared their transgender identity with their parents are exploring the topic of coming out and potential consequences; people who did come out are questioning whether their parents truly accept them for who they are. Having in mind either the absence of transgender topics in general public or their presentation in a sensationalist and pathologising way and the predominance of traditional patriarchal upbringing, many clients are preoccupied with actual and anticipated parental reactions and are extremely vigilant for signs of rejection. In this regard, in the therapeutic setting, one repeatedly encounters prevailing guilt (stemming mainly from the internalised anti-trans prejudice) that clients feel in the first place towards their parent/s. They are contemplating the consequences their (trans)gender identity and, for some, a decision to start and continue medical gender affirmation process, not just for themselves, but also for the everyday life and feelings of their parents and close family members. In these considerations they empathise with their families anticipated discomfort in interactions with broader social environment.

At the same time, young TGNB adults are quite often angry at their parents for the lack of understanding and support for the struggles they are going through but usually find it difficult to fully accept and express that anger. Stories may differ from family to family: some parents are reacting with open rejection and pathologisation of their identity; others are offering financial and logistic support but avoid providing emotional support and acceptance, thus leaving their child to struggle alone; some parents are trying to distance themselves from the process and avoid any conversation about the topic of gender or gender confirmation surgery and others are supportive in various ways but never ask questions first. Having this in mind, it is not surprising that young TGNB adults often question the sincerity of their parents' support, not just as a consequence of perceived stigma but as a result of their own experiences and interaction. Silence about the (trans)gender identity and the parental lack of initiative to start a conversation on that topic is especially challenging and interpreted as the lack of true acceptance and support. This struggle between guilt and anger results in silence and feelings of helplessness. These feelings are often generalised to both parents, even though – as with cisgender people – one's relationship with each of the parents is different and so are their expectations, fears, and hopes from them, as well as each parent's reactions to their child's gender identity.

Psychotherapeutic work with transgender clients in the circumstances of intense and long-term transgender psychopathologisation reveals the silver lining of a diagnosis: receiving a (psychiatric) diagnosis for many clients means that their gender identity and expression have been finally recognised and acknowledged. Given the strength of the medical/psychiatric discourse, it is often a diagnosis that gives legitimacy and provides a framework within

which transgender experience can acquire meaning and imbue the client with a sense of control over their lives. Psychiatric diagnosis relocates distressing transgender experience from the spheres of sin, criminality, or caprice where it has been traditionally located into the domain of medicine. This shift may attenuate some TGNB persons' feelings of guilt because their condition becomes a matter of scientific knowledge within which, as they expect, it will be professionally 'treated' rather than mocked, punished, or excluded. As long as the person is willing to succumb to the role of a patient, the medical discourse 'promises' not to consider them responsible for their 'condition' as well as to make it possible for them to reintegrate into the binarily gendered world following surgical interventions. Some people reported that healthcare providers further nourished that attitude, saying that they will 'stop having' the psychiatric diagnosis after their last gender confirmation surgery.

The period surrounding gender-affirming surgery is saturated with different meanings, both for trans people and their parents. Some clients report that their parents refuse to use the correct name and pronoun up until the surgery, as if this final body modification is the only and true determinant of their identity. There are different ways to understand this: as the need to keep what they believed was the identity of their child for as long as possible; as the hope that their child will change their mind in the last moment before the irreversible surgical intervention; but also as a manifestation of their understanding of the gender as determined by genitalia and the need for their child's identity to be verified by external authority (medical and/or legal). This corresponds with the importance of genital surgery for (some) trans people as well: waiting for the surgery is often exhausting, filled with uncertainty and fear that something might happen and delay the process even more. During this period it is often difficult to focus on anything else and make any long-term plans – the moment of surgery is decisive in their life, the turning point after which (as the person perceives it) everything will be different and easier. This dream of the 'new life' often leads to disappointment – even though the long-waited process of medical affirmation of gender is finally over, the following days and months bring back the same unresolved issues that the person has to face and deal with. What is important to understand is that this moment depends on somebody else: it is determined by different medical authorities (referral letter from two psychiatrists and one endocrinologist is required), schedules of the surgeons who will perform the surgery, and the number of surgeries determined by the Ministry of Health. These administrative procedures put a person in a passive role and it might be difficult to maintain the sense of agency in this process.

The question of the dis/continuity of life is also important for some people: what has happened before they started living their current gender

is forever lost in the past that should be forgotten. This moment – the beginning of an authentic life – may be different for different people but often is connected with the perception of the important other(s), with their current self finally being seen and mirrored by others (Fraser, 2009). This sense of dis/continuity that may be nurtured, but also disrupted by important others, poses a great challenge to a person, struggling to find their own narrative and be able to tell their life story with a deeper level of integration.

We should perhaps emphasise again that this psychotherapeutic support is provided within an activist organisation, free of charge and without any connection with the official (mental) healthcare system. This setting enables people to openly discuss different issues regarding their mental health and transgender identity without the fear that these thoughts and considerations will be interpreted as indicators that they are not 'trans enough', not 'psychologically stable enough' (to start with medical treatment), which might result in the delay of referral for the hormone treatment or different surgical interventions. Unfortunately, TGNP persons often share with their chosen psychotherapist outside of the medical team that they refuse to discuss their mental health issues (for example, overwhelming anxiety, depression, or suicidal ideation) or certain doubts about their identity or upcoming procedures with their psychiatrist from the gender identity team due to this fear, and thus are not able to receive adequate psychiatric support (including pharmacotherapy) that might reduce suffering, improve their mental health, and provide guidance in the process of medical transition.

Self-help group

Geten offers psychological support to TGNB persons in the form of individual counselling/psychotherapy as well as through the operation of a self-help group. As we have explored some of the major issues encountered in individual clinical work with TGNB population in Serbia, in this section we take a look at the Geten self-help group, the oldest of its kind in the post-Yugoslav region. The group, which gathers around twice per month, constitutes a fluid initiative and its membership fluctuates: for example, there are those who only attend a few meetings around their surgical transition as well as those involved for a few years regardless of any medical procedures. On the basis of our dataset generated through both our own semi-structured as well as published interviews with group members, we have identified three inter-related elements of group operation, which we would like to examine in further detail. These are: (1) information, support, and community, (2) navigating the medical/psychiatric system, and (3) dealing with gender binarism.

Information, support, and community

Joining the self-help group[9] can take place through various channels, but it most frequently occurs upon recommendation by current members as this ensures that the group stays a safe place for all of its participants. When someone wishes to join, the coordinators conduct an initial interview with the interested person with a view to evaluating their motivation. A new member then is often the first one to introduce themselves to other members of the group and share their experiences and expectations. In accordance with its guiding principle 'Support, self-esteem, security, and self-realisation', the group explores topics ranging from the body, identity, family relations, education and employment, transphobia and discrimination, transition experiences, sexuality, partner relationships, and relevant legislation. In this regard, the group operates as a safe-haven for TGNB people from both Serbia and other countries and it tries to forge cooperation with similar initiatives across the region and internationally. One of the most important, or at least most explicit, functions of the group is that it provides support and offers information about TGNB-related issues. As one interviewee states:

> It is the sense of community that the group gives that was important when I decided to join … A sense of belonging … The possibility to exchange experiences … It is easier to complain about bad experiences, like those with doctors, when there is someone who has gone through the same things as you have … So the group is an opportunity for us to learn about how others are coping with their problems … Sometimes you hear something positive, other times more negative, but regardless of that, there is someone you can identify with and someone who can understand you … What was crucial for me about the group participation was the fact that the group is a place where I could meet more trans people than anywhere else … Different trans people … There is that dimension of safe space … Especially when you do not know anyone … All of a sudden there is a room full of trans persons. (Personal communication, December 2019)

However, some interviewees talked about how there are limits to what can be actually shared among group participants. These mostly pertain to mental health-related difficulties that are not frequently brought up within the group and also because some group members may not be sure about how to name their emotional states. It seems that some participants avoid dealing with their psychological burden because they have a hard time establishing trust with their psychiatrists or they prefer to discuss it in individual psychotherapy/peer counselling like the one we explored in the previous section.

> My impression is that people think quite little about psychology and things related to it … I only realized what was happening to me when my psychiatrist told me 'look, that is a panic attack', so if people have emotional problems, maybe they talk about that with psychiatrists … But, on second thought, I doubt that anyone goes to confide in their psychiatrists … They go more to say 'please give me hormones, give me something for depression'. (Personal communication, December 2019)

The fact that psychological distress is rarely touched upon in discussions within the group or, for that matter, with a psychiatrist, reflects broader social patterns of stigma that is still attached to mental issues in contemporary Serbia, which has over the last three decades been strongly impoverished and repatriarchalised (Bilić, 2012). In the words of one group member:

> I think we are far from having a support group which would actually deal with people's psychological issues associated with being trans … But this applies to Serbia, more generally, regardless of whether you are trans or not … For example, I have experience with depression and when I go to my GP to ask for medication, she tells me 'oh, but you are too young to be depressed … why are you asking for this?' like … what the heck … as if I was just bored, so let's take some antidepressants … as a country we are still far away from knowing about the importance of mental health care. (Personal communication, December 2019)

Given that the group is a self-support group, which means that it is not led by professional psychotherapists and does not insist on regular attendance, according to some interviewees, many of its members may not be immediately aware of the beneficial effects the group meetings have on their mental health. In this regard, one interviewee stated that the protective dimension of the group is something he noticed only in hindsight as he 'looked back at his participation' (personal communication, December 2019).

Navigating the medical/psychiatric system

While raising personal issues related to mental health within the group may be contentious, there is much more consensus about the capacity of the group to help its members prepare for confronting the medical system, above all psychiatrists and endocrinologists. In this regard, many group members talk about their negative experiences in the medical domain. Regardless of whether they approached it in their capacity as patients or activists (or both), they felt that their knowledge was underappreciated and

that medical power overrode their accounts of their own lives. In the words of one group member:

> The Ministry of Health is the most conservative, not only here but in the region more generally … the door is completely closed … there are committees that write bills about us but do not consult us at all … not a single trans person participates in that … so people think they do not have any rights and they are not used to reacting or complaining. (Personal communication, December 2019)

The issue of power and its abuse is also reflected in the interactions with specific trans-specific healthcare providers.

> There is only one endocrinologist … if you complain about her, then how will you deal with your hormonal treatment? So doctors are really masters of fear … there is constantly a risk that you may stay even without that one doctor and then you say 'ok, let me bear with this, endure, stay silent, then at least I will manage to do what I want to do' … as long as they have so much power, they do not have any incentive to change anything … so there needs to be a shift in power relations … they are constantly fragmenting the community because they have so much power … they speak constantly in the media about trans issues … the focus is so much more on doctors than on activists … if you come to them and say 'wait, in my life it's not like that', doctors says 'how can you teach me about that when I know better, I am a doctor' … for example, if you go to see an endocrinologist and you do not address her as 'professor', she does not look at you … you must not say 'doctor', but 'professor' … these are horrible complexes they have. (Personal communication, December 2019)

With this in mind, preparing for an encounter with a psychiatrist and eventually meeting one (especially until 2019 and the latest policies of the World Health Organization) can be an intense and anxiety-fraught experience. This is due to the fact that a psychiatric assessment and the diagnosis are critical for receiving hormonal treatment and eventually proceeding towards surgery. Psychiatrists are mainly responsible for deciding the 'appropriate' moment for initiating hormonal therapy: thus, they can unnecessarily delay that process and amplify anxiety without providing sufficient information. In this regard, Đura Đuričić, one of the current co-coordinators of the self-help group, states:

> I went to see a psychiatrist in one of the health institutions with a view to beginning my transition process. It was already there that I felt

> disappointed because I had expected some sort of psychotherapy which I did not get. The whole process of starting hormonal therapy took me entire six years which was rather atypical and led me to anxiety as well as more pronounced gender dysphoria and depression. Such feelings did not help at the time when it was necessary for me to continue with the transition process. … During the transition, meetings with the psychiatrist take place once per month or less. I think that is too little for this kind of problem when we need to be supported and get advice. I believe that there should be a specific department dedicated exclusively to trans health so that there are sufficient slots and sessions with the psychiatrist and so that we do not have to compete for those slots with other patients. (As cited in Jeremić, 2017, online)

The self-help group serves as a platform for sharing knowledge about the medical procedures, 'required' behaviour on behalf of the people forced in the role of patients, and expected behaviour for healthcare providers. While considering a gender-affirming surgery, group members turn to their peers to learn about their experiences with overcoming the psychiatric 'hurdle'. This often means that, as is the case with TGNB people across the globe, group members engage in the gender confirmation process as a kind of performance where they are playing the role they believe is expected from them to successfully 'pass the test' and gain access to surgical procedures. As one interviewee states when describing the initial meeting with a psychiatrist:

> you need to say the right words, you need to act the norm … one guy in the group talked about how he was told by the psychiatrist 'you need to cut your hair, to go fishing' … it is incredible how stereotypical their protocols are … in the group we discuss this and aim to tell people how things stand … then it is their decision whether they want to lie or not … we are not encouraging anyone to lie but people do need to know how things work … they should know that they are taking that risk … some people have very fragile mental health exactly because they are not taking hormones and the whole process is being delayed … so they are waiting and cannot find a job. (Personal communication, December 2019)

Having in mind the long history of psychiatric gatekeeping and the 'one-treatment-fits-all' approach, characterised by the lack of sensitivity to individual needs of different people, group members are often willing to engage in this performance. As a consequence of such 'artificial' interaction, mental health-related knowledge is generated within the official medical system not on the basis of the real experiences and needs of transgender people, but on their attempt to conform to the perceived and internalised

expectations of the medical authority, which leads to further alienation from care providers. This is especially problematic given that members of the group also state that they feel 'used' by medical professionals curious about TGNB persons. Đura Đuričić, states:

> [When I went to see a psychiatrist] my impression was that I was there because of the doctor, helping him to get more information about transgender condition rather than to be helped myself. From the very beginning I knew who I was and what I wanted and I did not need a doctor's endorsement, I did not have any doubts about the surgery. (As cited in Jeremić, 2017, online)

This idea that TGNB persons are 'used' as sources of information that is then processed without their direct involvement or benefit also appears in relation to another TGNB group that is led by a psychiatrist working at the national clinic. One self-help group participant went to a few meetings of the other group only to notice that the group leader (psychiatrist) was overly distant allowing conflicts among group members to surface in an aggressive manner. This interviewee states:

> I had a feeling that we were like guinea pigs there … like here you are, you should talk and I will observe and learn on the basis of your behavior how a trans person should look like, how they should behave … her understanding of the trans issue can be reduced to binarity … that is the only thing she has learned from the book that they are using … there is another psychiatrist who is learning a bit more, but she is also quite conservative … I heard these psychiatrists complaining that people just disappear after their surgeries and never show up again leaving them without any feedback … and they would need that feedback for the Ministry … yeah, but I wonder why they disappear. (Personal communication, December 2019)

When asked about the differences between the two groups, the self-help group and the one at the clinic, the interviewee who briefly participated in both says that the one led by a psychiatrist is attended more by those people who do not approach the medical model critically or are much less likely to put it in question. Thus, this interviewee also points to an increasing critical consciousness among the trans people towards the healthcare that is being developed in the activist context that is, in the context of the group. He states:

> those going to the other group have a more 'medical' outlook … some of those who are coming here also have that 'outlook', but they are open for communication and it is possible to explain to them that

> that way of looking at things is not the only one … I don't have in mind only gender binarism but the idea that transgender is a mental disorder … I met a lot of trans people used to the idea that they had a mental disorder … I remember one guy lying next to me at the hospital when we had our surgeries and he held such a worldview … I was shocked … one trans girl came saying 'I am lesbian, I do not have any problems with my genital organs and I do not want a surgery' … after she said that three persons reacted immediately saying 'Then, you are not trans, you have issues', so such patronizing stupidities were said … and the group leader did not react to that at all … even though the girl was there for the first time … that was one time I witnessed such a thing whether members of the group tried to impose on other how they should feel and after that I stopped going there … it looked like the group coordinator's role was only to observe and to learn. (Personal communication, December 2019)

Dealing with gender binarism

As is obvious from above, throughout the interviews, gender binarism appears as the dominant issue that group members have to negotiate both in their personal lives as well as in group meetings. In her study with 28 members of the self-help group done in 2012, Zulević noted that the majority of those who joined went through the complete process of surgical gender affirming even though the group also welcomed those who were not interested in medical interventions or at least not in a complete physical transition. 'Incomplete' bodily modifications, however, were not legally allowed in Serbia at the time of Zulević's research and partially done surgeries[10] were more a consequence of the lack of financial means for covering all of the necessary interventions. In this regard, legal regulation reflected deeply entrenched perceptions about the social world being divided into two genders, which have to a great extent persisted up to this day colouring the operation of the group. In the words of Aleksa Milanović, a long-term group member:

> A huge number of trans people, especially in Serbia, want to enter into transition as soon as possible, to get a diagnosis quickly, start with hormones, do surgeries and blend into the society … They do this in order to protect themselves and decrease discrimination. In the West, also a huge number of people want to go into the process of gender affirmation, but there is also a huge number of those who do not want to modify their bodies, but do want to change their gender identity. I personally have not done any medical interventions, my transgender identity comprises me using masculine pronouns and a

> name which is considered masculine in my environment. (As cited in Galić, 2018, online)

The adherence to the idea of gender binarism would perhaps not be so strong within the group were it not reinforced by the dominant psychiatric discourse encountered, in one form or the other, by many TGNB persons across the region. As one person states:

> psychiatrists are, in principle, promoting the following view: you have gender dysphoria, you have the so-called F64 diagnosis and your cure for that is surgery … once your surgery is done, that diagnosis will disappear, meaning that you are no longer trans … you are then a man or a woman … but it's not like that only in Serbia. (Personal communication, December 2019)

Gender binarism is reflected in the psychiatrists' prototype of an ideal candidate for hormone-surgical treatment: as a person who finds their identity in gender binary and traditional gender roles, including heterosexual orientation.

> We recently had a regional meeting and many people said that those who would admit to their psychiatrists that they were non-binary would unnecessarily prolong their hormonal treatments and the whole procedure … it is similar with non-heterosexual information … maybe it is now a bit better than it used to be, but it is still like that … interestingly enough, psychiatrists still tend to ask you also about your sexual orientation … like who you go out with … even though that is completely irrelevant.

The fact that many people do not only sever their links with their psychiatrists, as one group member pointed out above, but also stop coming to group meetings[11] once their gender-affirming surgery has been completed, testifies to the power of binary gender conceptions among the group members. They seem less interested in being associated with the Belgrade trans collective when they start feeling more secure about being a man or a woman (for example, there is currently only one person who continued to attend the meetings after surgery).The pressure to conform to the gender norm – which constitutes the basis for (internalised) transphobia – manifests itself during or around group meetings marginalising, in turn, non-binary persons. As one member states:

> transphobia is appearing within the group as hypermasculinity or hyperfemininity … like one trans woman telling another that she

> 'does not look like a woman enough' … like she is not wearing makeup or taking care of her looks … the argument is that by not presenting herself as a 'woman enough', she makes it easier for others to understand that she is actually trans … however, I should add that people rarely raise such issues in group discussions, it is more something that is said 'on the fringes' and individually, but not when we are sitting in a circle … It is for sure that there is not enough space within the group for non-binary people, probably also because there are so few of them … so in the 90 per cent of cases, the discussion within the group slides into the medical issues … non-binary people who are not interested in any surgeries can get a bit bored. (Personal communication, December 2019)

When asked whether there are any generational differences regarding the need to conform to gender norms, especially in view of recent intensification of trans activist engagement on the global scale, one group member states:

> In the group there are people from 18 to 50 years of age … there is a generational difference in the sense that younger people do not really perceive doctors so much in terms of their authority, but older people still do … they see them a lot as an authority … so young people are generally more informed and open … and especially more open to dating other trans people as well as to experimenting with various ways of expressing their gender identity … this was not so much the case with my generation. (Personal communication, December 2019)

Irrespective of the fact that it may still be unsure about how to confront the challenge of reproducing gender norms that are at the root of gender-related oppression, the Geten self-help group represents a crucial convergence point for TGNB people in Serbia and the region. In the local milieu still characterised by high levels of transphobia, there is hardly another place with such a concentration of trans-related knowledge. In this regard, the group goes beyond an immediate empowerment to constitute an epistemic community engaged in developing a critical and analytical perspective vis-à-vis the norms of medicine as well as in continually negotiating and acknowledging embodied trans experience. While the group for the time being lacks wider social visibility, the experience of its members has informed the legal solutions that Geten has proposed to destabilise the gender norm and advance the social status of TGNB people in the country. With the legal weakening of the psychiatric dimension in TGNB lives, it is to be expected that the official institutions providing trans (mental) healthcare will increasingly turn to such community initiatives for information and advice.

Conclusion

The field of transgender health has been recently going through an unprecedented change brought about by decades of sustained trans activist engagement. As an identity-based model of trans health is slowly replacing a disorder-based model, TGNB persons' experiences with health provisions are improving. This is clearly visible in the highly dynamic political context of today's Serbia in which issues encountered by TGNB individuals differ greatly as a function of the period in which they started socially and/or medically affirming their gender over the last three decades. However, in spite of the evolution in the domain of surgical interventions and the higher visibility of trans-related topics in the media, trans mental health has remained an area that warrants further attention. Our trilateral approach, comprising a survey with TGNB persons, observations from clinical work, and interviews with members of the self-help group, points to the prevalence of negative experiences with and emphasises the necessity for improving mental health services. We have shown that the medical/pathologising outlook on trans lives based on the idea of gender binarism is still surprisingly resilient posing an obstacle to TGNB people's willingness to seek mental health assistance.

The hegemony of the medical model in Serbia, in contrast to some other post-Yugoslav states,[12] cannot be separated from the fact that gender-affirming surgeries have been regularly taking place in Belgrade since the 1980s. Given that groundbreaking surgical interventions had started years ahead of any activist claims for transgender liberation, the rapidly accumulating medical knowledge has quickly gained the upper hand over the voice of trans persons themselves.[13] The first more differentiated as well as publicly and collectively articulated trans grievances appeared only in the wake of democratic changes that started with the fall of the Slobodan Milošević regime in October 2000. By that time the medical discourse on 'transgender condition' had been already firmly rooted not only in psychopathology but also in the idea that sex and gender are overlapping binary categories. Sava Perović, Professor of Urology at the University of Belgrade Faculty of Medicine, was at the helm of the team that started performing gender-affirming surgeries. In an interview, conducted in 2003, once he had already earned an international reputation for his work, Dr Perović talked about a patient who in the early 1980s approached him with a request for a surgical intervention that would change his genital organs. Dr Perović stated:

> 'I refused that first patient three times, but then primarius doctor Zoran Rakić, who was dealing with the issues of transsexualism sent me a letter in which he explained that what was at stake was indeed a real medical disease (prava medicinska bolest) and that it had to do with a gender identity disorder. It was a male person with a female

> brain and the changes were in the (brain) cortex. I was looking for a solution in the existing literature, but given that I could not find anything, I decided to perform a surgery on the basis of my knowledge. It was successful and after it I started a series of such surgeries here (kod nas) and published a paper about a new surgical technique in the world leading journal of plastic and reconstructive surgery. Ever since then our clinic has been visited by foreigners who want to be operated and I am invited to clinics around the world. At the same time, wars broke out here leading to isolation and everything that happened to us, but nevertheless, I managed to obtain visas and continue performing surgeries.'

Dr Perović understood that being unable to fully affirm one's gender due to social constraints was a source of mental distress[14] and that a multidisciplinary approach was the only viable strategy towards effective trans healthcare (Kovačević, 2003).[15] However, even though he had a lot of media presence and became a member of the Serbian Academy of Sciences and Arts on the basis of his surgical innovations, he kept – in accordance with the then global trends – positioning trans people in pathologising contexts without acknowledging discrimination or problematising the way in which the social environment proscribed gender variance. He never demanded legal action that would improve the social status of trans people or at least the way in which his colleagues perceived them (Đurić, 2012). Dr Perović was known for his insistence that people willing to undergo gender-affirming surgery should not be allowed to do so if they admit that they would be homosexuals after they transition. In a lecture for the general public which he gave at the National Library of Serbia in 2005 he expressed such a stance saying that some members of staff at his clinic refused to enter a room with trans patients because they considered them homosexuals (Deve, 2005; Đurić, this volume; Đurić, 2012). Given that Dr Perović was the leading figure in the trans domain in Serbia and internationally as well as the principal mentor for urogenital surgeons at the Belgrade Faculty of Medicine, his rather conservative ideas about gender diversity had a profound impact on the national medical science for almost three decades. There is still only one medical gender team in the country reflecting high levels of Serbian state centralisation and perpetuating the fissure in access to healthcare between urban and provincial/rural populations.[16] On the other hand, it is also important to keep in mind that position of members of the medical gender team among the broader medical community. The very fact that the work of the team was officially recognised by the relevant medical professional organisation only in 2012, when the Committee was founded, is an example of the associated stigma they faced among their peers.

The most active period of Dr Perović's professional life to a great extent coincided with the intense process of repatriarchalisation that preceded and accompanied the wars of the Yugoslav succession and the fall of Yugoslav socialism. The late 1980s and the early 1990s witnessed a rapid dismantling of the emancipatory achievements of the socialist regime that particularly affected the area of reproduction and gender relations. After sustained policy measures that aimed at improving the social status of women and decriminalise homosexuality in the second half of the 20th century, all of the (former) republics went through a 'calcification' of gender roles undergird by sensationalistically propagated demographic concerns. Given that the unprecedented modernisation impulse of the socialist regime never really managed to destabilise deep patriarchal roots, nationalist politics that culminated in an armed conflict also manifested themselves in the form of 'gender wars' (Slapšak, 2013, p 255) comprising high levels of misogyny, homophobia, and transphobia. In such challenging circumstances, some of the already fragile streams of Yugoslav feminist engagement could not altogether resist the patriarchal assault and ended up assuming radical feminist positions unsupportive of the transgender cause (Bilić, this volume; Bilić, 2020). This was also aggravated by strong neoliberal tendencies of activist professionalisation that radically narrowed and fragmented the field of political struggle by zooming in on particular identities and increasingly foreclosing the possibilities of intersectionally sensitive initiatives. Such a situation dispersed TGNB people and contributed to their marginalisation by depriving them of a feminist refuge.

Once nationalism subsided as the central axis of official political life towards the end of the 1990s and in the early 2000s, some of its strongest elements survived by withdrawing into the fields of psychiatry and psychology. The sphere of mental health, always already immersed in political contestations, became a new discursive battleground on which conservative/traditional perspectives about what constitutes 'normal' gender and sexuality expression clashed with much more subdued but resilient liberal currents. Mental health professionals were no longer crucial only for 'managing' personal destinies but were effectively turned into a 'bulwark' against the 'decadent influences of the West', which were supposedly determined to deal a final blow to the already weakened 'traditional' Serbian family. In this regard, professional medical/psychiatric organisations may show serious delays in absorbing emancipatory LGBTIQ+ legal norms due to the power that middle-class heteronormative (male) psychiatrists tend to hold in patriarchal environments.[17] Given that they are generally perceived as 'objective' experts without immediately visible political commitments, conservative mental health professionals may be influential in framing public debates around LGBTIQ+ issues in a way that modulates progressive legislation and truncates its potential to diffuse across the social field. Mental issues, thus, have a hard time detaching

themselves from the layers of social stigma that have thickened across decades characterised by violence, isolation, and authoritarianism.

In such circumstances, little reliable information about trans issues or gender and sexual non-normative identities, more generally, circulate within clinical or academic settings. LGBTIQ+ topics have been for a lot of time insufficiently or inadequately represented in Serbian higher education institutions,[18] mainly in the courses other than those dealing with mental health (such as biological psychology, gender studies, history of psychology) and in pathologising and insulting manner (for example, the major psychiatry textbook [Jašović Gašić and Lečić Toševski, 2007] used by both psychology and medicine students in which it is, for example, stated that trans people try to 'simulate the phenotype of the opposite sex'). With this in mind, it is not surprising that a recent survey about transgender health, which brought together Georgia, Poland, Serbia, Spain, and Sweden (Smiley, 2017), demonstrated that Serbia was the only country where no healthcare providers identified as trans. This remarkable lack points to the history of the health system's closure towards TGNB individuals and continues to obstruct their engagement with (mental) health services.

However, while the reluctance to seek professional psychological help is rather general, it is in the case of TGNB people exacerbated by the dual role of mental health professionals who do work in the sphere of trans-specific healthcare. For the time being, those people who are responsible to decide about access to hormonal treatment and surgical interventions are also supposed to provide psychological help to them, especially given the shortage of mental health professionals and the fact that many TGNB persons cannot afford private/individual psychotherapy. Such an arrangement can seriously affect the therapeutic alliance between the mental health professional and the client and may distance TGNB individuals from engaging with therapeutic services due to the fear of compromising their treatment (Smiley et al, 2017). It is therefore imperative to increase the number of mental healthcare providers and to arrange further training in the domain of trans-specific mental health services. In doing so, both state institutions and private practitioners can benefit from the knowledge that has over the last 20 years accumulated within LGBTIQ+ activist organisations and, in particular, the Geten self-help group.

Updating mental health services is particularly important in the period in which transgender has officially ceased to be a clinical category. In their *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, the American Psychological Association (2015) states that a non-binary understanding of gender is fundamental to the provision of affirmative care for TGNB people. The Association calls for psychologists and other mental health professionals to take a leadership role in ending transphobic discrimination. Although significant advances in this direction have taken

place over the last years, Serbia, along with many of its neighbours, has structural rule of law difficulties that distort law implementation. New non-discriminatory legal solutions are, nevertheless, crucial and it is to be expected that the bill about gender identity and the rights of intersex persons, proposed by Geten, should be adopted in the near future. It will constitute a platform upon which community-generated knowledge can be shared among all interested parties. Activist organisations' alternative forms of mental healthcare and support, which are in synchrony with the global movement for gender and non-heterosexual liberation, can certainly help to transform mainstream mental health policies rendering them more sensitive to the needs of TGNB individuals.

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Notes

1. This is an extended version of the paper: Vidić, J. and Bilić, B. (2021) TGNB persons, mental health, and gender binarism in Serbia. *Journal of Gay and Lesbian Mental Health*, *25*, 2, 155–74. DOI: 10.1080/19359705.2020.1850596
2. The name of the organisation was inspired by the androgynous world of Gethen from Ursula Le Guin's novel *Left Hand of Darkness*. In 2016, the organisation received the writer's formal permission to use Gethen (in Serbian, Geten) as its name, and in 2019 the name of the organisation was officially changed from Gayten-LGBT to Geten.
3. ICD-10 still used the term 'opposite sex' assuming the gender binary; both DSM-V (2013) and ICD-11 use 'other gender'.
4. According to Reisner et al (2016a), 'a participatory population perspective necessitates working with – and not through – local, national, and global transgender-led organisations in the conduct of research and evaluation, delivery of gender-affirmative clinical care, education and training, and policy and advocacy'.
5. The law and the bylaw were adopted as a part of the accession process to the European Union. However, relevant non-governmental organisations were not invited to participate in the working groups, and the original version of the rulebook stipulated hormone treatment and (not either/or) surgical interventions as a requirement for legal gender recognition. The change from 'and' to 'either/or' was made in the last minute before its official adoption after Geten's urgently invited European NGOs and institutions to exert pressure on the working group with the view of giving up surgical interventions (basically sterilisation) as a requirement.
6. Zulević (2012) notes that those TGNB persons who did their gender-affirming surgery before 2000 report that they were sometimes asked by the medical staff to give presents in the form of jewellery or other valuables so that the intervention could be performed smoothly.
7. This bill is available in Transserbia (2019).
8. The sample does not reflect the general population in this regard.
9. The participants understand that one of the problems of trans organising is that it is very Belgrade-centred. As one group member states: 'mostly people from Belgrade come to the group … or those who have moved to Belgrade … so we cannot really reach those

who live in Niš or in other parts of Serbia … we cannot do that … how could we? We would need much more resources, funds, time … So, in that regard, our situation here [in Serbia] is more complex than, for example, in Montenegro which is smaller and it may be easier to reach the capital … Everything is more complicated the further you are from Belgrade' (personal communication, December 2019).

10 The option of partial transition was introduced by the fifth version of the WPATH standards of care from 1998. See Levine et al (1998).

11 One group member (personal communication, December 2019) states: 'until now it has mostly been the case that people, once they are done with the surgery, they also want to be done with that stage of their lives, they are not interested in mentioning it ever again, they think it would be the best if no one ever knew about them'.

12 This is due to the fact that in other capitals of the Yugoslav republics, gender-reaffirming surgeries were not possible throughout the 1980s and are still unavailable in some of them up to this day.

13 This may share certain affinities with the fact that the decriminalisation of homosexuality in Serbia, which took place in 1994, also did not stem from activist efforts but occurred rather as a result of a routine revision of the Penal Code. Such a legal act that preceded more visible forms of activism had a profound effect on the development of gay engagement in the following years: it prevented activists from going through a crucial public 'legitimisation' stage and left thick layers of social homophobia untouched while declaratively allowing homosexuality.

14 In the same article, it is stated (Kovačević, 2003, online): 'Sex change should certainly be accompanied by a complete personality change. That is why sex change should be done while the patient is still a baby and the environment does not know their sex. But when it comes to adults, psychological traumas are not negligible. We have seen that physical appearance, that is the external part, can be successfully modified. However, are there ways of changing the soul which is an integral part of one's personality? Even after thirty years in surgical wards, Dr Perović still has not found such a way: "That is almost impossible. On this level of medical development there are some biochemical studies that are trying to find the cause and target that [psychic, BB] aspect of the human being, but so far they have been unsuccessful."'

15 In the same interview, he stated (Kovačević, 2003, online): 'At the last world congress in which I took part, which was devoted to transsexualism, that is, to the disorder of gender identity, there was a whole team of experts including psychiatrists and psychologists, surgeons, social workers. Without a multidisciplinary approach, there can be no cure for such patients and that functions in the West, but here unfortunately not.'

16 Such an arrangement leaves a lot of space for the few specialised doctors to have a monopoly over the field of transgender health in Serbia. In this regard, Jelena Simić (On-Off, 2019, online), a member of the Geten legal team, states: 'Over the last 30 years, the major problem of trans people in Serbia was the legal lacuna … You did not have a single legal document about trans persons. That changed in 2011 and that was a boom for us jurists given that in that year the law on health insurance was changed. … After that, jurists became more flexible and started asking doctors how to regulate that field. … I have to say that it is exactly our doctors, and their number is not that high, even though we were the first in this part of the world to deal with this question and reached a very high level … unfortunately I have to say that the ethics of those [medical] experts failed in this case. In no way did they contribute to the improvement of the status of transgender people. It is exactly our psychiatrists and endocrinologists who are obstructing the procedure of legal recognition … There is a monopoly of certain doctors who deal with these issues … In order to control or to work in this field, you need to have specialized knowledge

… There are here few such doctors and they are playing the role of gatekeepers, they see themselves as guardians of the society, of social values … Even though they are members of eminent international organisations that deal with transgender conditions … So, if I can say so, it is really hypocritical that they are respected members of those organisations where practices and approaches are being improved over the last three decades … Thus it is certainly not a matter of a lack of knowledge … I can only express a doubt that there is that lucrative dimension which is quite pronounced among our doctors … Because if you have one endocrinologist in the whole country, even if the number of transgender people is not that great, try making an appointment in a state institution … All of the patients are being diverted to private practice.'

[17] For example, it took the Belgrade-based lesbian activist organisation Labris years of effort (until 2008) to persuade the Serbian Medical Society to acknowledge the World Health Organization's declassification of homosexuality (1990) as sexual deviation.

[18] In this regard, there are two studies conducted by the Gayten-LGBT team and coordinated by the first author: in 2015, 65 medical workers (GPs, specialists, and nurses) were asked about their attitudes towards LGBTIQ+ persons via an online survey (Vidić, 2020b). This study showed that the level of familiarity with trans issues was rather low – the participants answered correctly to around a half of 12 trans-related questions while no participant provided a correct answer to all of the questions. More than a half stated that a transgender person who has not gone through a surgical transition should be addressed in accordance with their legal documents. Even though the sample was self-selected, more than a half stated that they had never encountered topics around homosexuality or gender identity during their either general or specialist medical training. In the second, unpublished study conducted in 2017, 195 participants including students of psychology (70.3 per cent), social work (22.6 per cent), medicine (3.1 per cent), and law (4.1 per cent) were asked a set of questions regarding inclusion of LGBTIQ+-related matters in their curricula. A vast majority (73.8 per cent) stated that they encountered LGBTIQ+ topics at the faculty. When it comes to gender identity, more specifically, the examined students stated that the issue was covered in an affirmative way (32.3 per cent), neutral way (33.3 per cent), or in a pathologising way (6.7 per cent), while 22.1 per cent reported that the topic was not covered at all. When asked whether their courses covered the topic of working with transgender people, 56.9 per cent gave a negative answer, 12.3 per cent stated that it was covered in an affirmative way, in a neutral way (10.8 per cent), and in a negative way (8.2 per cent). One psychology student observed that non-heterosexual and trans people are mentioned only 'along the way', but that they are not formally included in the syllabi of any courses. The same participant emphasised that questions regarding LGBTIQ+ tend to be raised by students rather than by lecturers.

References

American Psychological Association. (2015) Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832–64.

Aylagas-Crespillo, M., García-Barbero, Ó., and Rodríguez-Martín, B. (2018) Barriers in the social and healthcare assistance for transgender persons: A systematic review of qualitative studies. *Enfermería Clínica*, *28*(4), 247–59.

Bilić, B. (2012) *We were gasping for air: (Post-)Yugoslav anti-war activism and its legacy*. Baden-Baden: Nomos.

Bilić, B. (2020) *Trauma, violence and lesbian agency in Croatia and Serbia: Building better times*. London: Palgrave Macmillan.

Bockting, W.O., Miner, M.H., Swinburne Romine, R.E., Hamilton, A., and Coleman, E. (2013) Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, *103*, 943–51.

Breger, J., Green, R., Laub, D., Reynolds, C, Walker, P., and Wollman, L. (1979) *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons* (1st edn). San Francisco: Harry Benjamin International Gender Dysphoria Association.

Budge, S.L., Adelson, J.L., and Howard, K.A.S. (2013) Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, *81*, 545–57.

Deve. (2005) *Razumevanje, predavanje u Narodnoj biblioteci Srbije*. Belgrade: Deve.

Đurić, M. (2012) Transpolnost u Srbiji. *Optimist*. Retrieved on 23 January 2020 from www.optimist.rs/transpolnost-u-srbiji/

Fassinger, R.E. and Arseneau, J.R. (2007) 'I'd rather get wet than be under that umbrella': Differentiating the experiences and identities of lesbian, gay, bisexual, and transgender people. In K.J. Bieschke, R.M. Perez, and K.A. DeBord (eds) *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp 19–49). Washington, D.C. American Psychological Association.

Fraser, L. (2009) Depth psychotherapy with transgender people. *Sexual and Relationship Therapy*, *24*(2), 126–42.

Galić, N. (2018) Intervju sa Aleksom Milanovićem, aktivistom Trans mreže Balkan. Retrieved on 27 January 2020 from www.transbalkan.org/intervju-sa-aleksom-milanovicem-aktivistom-trans-mreze-balkan/

Grant, J. M, Mottet, L.A., Tanis, J., Harrison, J., Herman, J., and Kesiling, M. (2011) Injustice at every turn: A report of the national transgender discrimination survey. Washington: National Center for Transgender Equality & National Gay and Lesbian Task Force. Retrieved on 27 January 2020 from www.thetaskforce.org/wp-content/uploads/2019/07/ntds_full.pdf

Ho, F. and Mussap, A.J. (2017) Transgender mental health in Australia: Satisfaction with practitioners and the standards of care. *Australian Psychologist*, *52*, 209–18.

Jeremić, M. (2017) Superheroj Đura: Budite svoji i ne odustajte. Retrieved on 27 January 2020 from www.transserbia.org/trans/transrodnost/1203-superheroj-djura-budite-svoji-i-ne-odustajte

Kovačević, L.J. (2003) Skalpelom kroz svet. Interview with Dr Sava Perović. *Planeta: Magazin za nauku, istraživanja i otkrića*. Retrieved on 23 January 2020 from www.planeta.rs/05/5naukakaozivot.htm

Levine, S., Brown, G., Coleman, E., Cohen-Kettenis, P., Maasdam, J., Pfafflin, F., and Schaefer, E. (1998) *The standards of care for gender identity disorders* (5th edn). Dusseldorf: Harry Benjamin International Gender Dysphoria Association.

Marković Žigić, D., Zulević, J., and Maksimović, K. (2015) Rad sa transseksualnim klijentima – specifičnosti tranzicije i izazovi nakon nje. In V. Miletić and A. Milenković (eds) *Priručnik za LGBT psihoterapiju* (pp 172–88). Belgrade: Udruženje za unapređenje mentalnog zdravlja.

McCann, E. and Sharek, D. (2016) Mental health needs of people who identify as transgender: A review of the literature. *Archives of Psychiatric Nursing*, *30*, 280–85.

McConnell, E.A., Birkett, M., and Mustanski, B. (2016) Families matter: Social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *Journal of Adolescent Health*, *59*, 674–80.

McNeil, J., Bailey, L.. Ellis, S., Morton, J., and Regan, M. (2012) *Trans mental health and emotional wellbeing study 2012*. Retrieved on 5 February 2020 from https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_mh_study.pdf Scottish Transgender Alliance; TREC, Traverse; Sheffield Hallam University, TransBareAll.

Miroslava Jašović-Gašić, M. and Lečić-Toševski, D. (eds) (2007) *Psihijatrija za studente Medicinskog fakulteta u Beogradu*. Belgrade: Medicinski fakultet.

On-Off (2019) Biti transrodan u Srbiji. Retrieved on 3 February 2020 from www.youtube.com/watch?v=aDZj-Z6ZNVU

Reisner, S.L. Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., Holland, C.E., Max, R., and Baral, S.D. (2016a) Global health burden and needs of transgender populations: A review. *Lancet*, *388*, 412–36.

Reisner, S.L., Keatley, J., and Baral, S. (2016b) Transgender community voices: A participatory population perspective. *The Lancet*, *388*, 10042.

Robles, R., Fresan, A., Vega-Ramirez, H., Cruz-Islas, J, Rodrigues-Perez, V., Dominguez-Martinez, T., and Reed, G. (2016) Removing transgender identity from the classification of mental disorders: A Mexican field study for ICD-11. *Lancet Psychiatry*, *3*, 850–59.

Simons, L., Schrager, S.M., Clark, L.F., Belzer, M., and Olson, J. (2013) Parental support and mental health among transgender adolescents. *Journal of Adolescent Health*, *53*, 791–3.

Slapšak, S. (2013) Žene, Jugoslavija, antikomunistička narkoza i novi kolonijalizam: Mape, putevi, izlazi. *Poznańskie Studia Slawistyczne*, *5*, 249–63.

Službeni glasnik RS. (2018) Pravilnik o načinu izdavanja i obrascu potvrde nadležne zdravstvene ustanove o promeni pola (br. 103). Retrieved on 20 February 2020 from www.pravno-informacioni-sistem.rs/SlGlasnikPortal/

Smiley, A., Burgwal, A., Orre, C., Summanen, E., Garcia Niento, I., Vidić, J., Motmans, J., Kata, J., Gvianishvilli, N., Hard, V., and Kohner, R. (2017) *Overdiagnosed but underserved: Trans healthcare in Georgia, Poland, Serbia, Spain, and Sweden – Trans health survey*. Malmö: TGEU.

Smith, E., Jones, T., Ward, T., Dixon, J., Mitchel, A., and Hilier, L. (2014) *From blues to rainbows: The mental health and well-being of gender diverse and transgender young people in Australia*. Australian Research Centre in Sex, Health and Society. Melbourne: La Trobe University and University of New England.

Taliaferro, L.A., McMorris, B.J., and Eisenberg, M.E. (2018) Connections that moderate risk of non-suicidal self-injury among transgender and gender non-conforming youth. *Psychiatry Research*, *268*, 65–7.

Testa, R., Sciacca, L., Wang, F., Hendricks, M., Goldblum, P., Bradford, J., and Bognar, B. (2012) Effects of violence on transgender people. *Professional Psychology: Research and Practice*, *43*(5), 452–9.

Transgender Equality Network Ireland. (2013) *Speaking from the margins: Trans mental health and wellbeing in Ireland*. Dublin: Teni.

Transserbia. (2019) Model zakona: Zakon o rodnom identitetu i pravima interseks osoba. Retrieved on 20 February 2020 from https://www.transserbia.org/files/9sep19_MODEL_ZAKONA_RODNI_IDENTITET_I_INTERSEKS-1-3.pdf

Turner, L., Whittle, S., and Combs, R. (2009) *Transphobic hate crimes in the European Union*. London: Press For Change.

Valentine, S.E. and Shipherd, J.C. (2018) A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review*, *66*, 24–38.

Veale, J.F., Watson, R.J., Peter, T., and Saewyc, E.M. (2017) Mental health disparities among Canadian transgender youth. *Journal of Adolescent Health*, *60*, 44–9.

Vidić, J. (2020a) Položaj i potrebe transrodnih i rodno nebinarnih osoba u Srbiji. *Psihološka istraživanja*, *24*(1). https://doi.org/10.5937/psistra24-27858

Vidić, J. (2020b) Transrodnost u Srbiji u 21. veku – pilot studija o informisanosti i iskustvima zdravstvenih radnika u procesu prilagođavanja pola. *Engrami*, *42*(2), 6–22.

Vidić, J. and Bilić, B. (2021) TGNB persons, mental health, and gender binarism in Serbia. *Journal of Gay and Lesbian Mental Health*, *25*(2), 155–74.

Vujović, S., Popovic, S., Sbutega-Milosevic, G., Đorđević, M., and Gooren, L. (2009) Transsexualism in Serbia: A twenty-year follow-up study. *Journal of Sexual Medicine*, *6*, 1018–23.

White, B.P. and Fontenot, H.B. (2019) Transgender and non-conforming persons' mental healthcare experiences: An integrative review. *Archives of Psychiatric Nursing*, *33*, 203–10.

World Health Organization. (2016) *International statistical classification of diseases and related health problems* (10th edn). Retrieved on 28 September 2019 from https://icd.who.int/browse10/2016/en

Zulević, J. (2012) Istraživanje problema transeksualnih osoba u sferama školstva, rada I zapošljavanja, zdravstvene zaštite i državne administracije. In S. Gajin (ed) *Model zakona o priznavanju pravnih posledica promene pola i utvrđivanja transseksualizma. Prava trans osoba: Od nepostojanja do stvaranja zakonskog okvira* (pp 27–49). Belgrade: Centar za unapređenje pravnih studija.